



PATIENT: _____
EMPLOYEE: _____
CLAIM NO: _____
PROVIDER: _____

GROUP NO: _____
ACCT NO: _____
INCURRED: _____
CHARGE: _____

Dear Participant:

We have received a claim for the patient listed above. Before we can consider this claim, please be advised that this plan has a pre-existing limitation.

Recent changes in Federal law may effect your health coverage if you enrolled or become eligible to enroll in health coverage that excludes coverage for a pre-existing medical condition.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior coverage. Please refer to your plan document to find the pre-existing limitation which applies to your plan.

A certificate of prior coverage must be presented to HealthComp Administrators, Inc. in order to reduce your pre-existing exclusion period.

Please submit your certificate(s) of prior health coverage to:

Healthcomp Administrators
P.O. Box 45018
Fresno, CA 93718-5018

If there was no prior coverage, or a certificate is being requested, please use the section on Page 2 to sign & date this letter and return to our office within ten (10) days.



Page 2 of 2 Patient Name: _____

The requested information must be received by HealthComp within forty-five (45) days from the date of the initial request or the claim will be denied/closed.

For additional information, please contact HealthComp Administrators, at (800) 442-7247. Fax (559) 499-2464

Sincerely,

HealthComp Administrators
Claims Department

Please attach a copy of your Certificate of Creditable Coverage from the prior carrier and forward to HealthComp Administrators.

Signed _____ Dated _____

_____ No prior coverage.

Signed _____ Dated _____